MassHealth

Billing Guide for the CMS-1500 Paper Claim Form

Executive Office of Health and Human Services
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Introduction

This guide provides detailed instructions for completing the paper CMS-1500 claim form for MassHealth billing. Additional instructions on other billing matters, including member eligibility, prior authorization, claim status and payment, claim correction, and billing for members with other health insurance, are located in Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the MassHealth Guide to the Remittance Advice and Electronic Equivalents.

General Instructions for Submitting Paper Claims

CMS-1500 Claim Form

The following providers must use the CMS-1500 when submitting paper claims to MassHealth:

- abortion clinics
- acute inpatient hospitals (for professional services provided by hospital-based physicians only)
- acute, chronic, and psychiatric outpatient hospitals (for professional services provided by hospital-based physicians only)
- adult day health providers
- adult foster care providers
- audiologists
- chiropractors
- community health centers (professional services only)
- day habilitation providers
- durable medical equipment providers
- early intervention providers
- family planning agencies
- freestanding ambulatory surgery centers
- group adult foster care providers
- hearing instrument specialists
- home-care corporations (elderly waiver)
- hospital-licensed health centers (for professional services provided by hospital-based physicians only)
- independent clinical laboratories
- independent diagnostic testing facilities
- independent living centers
- independent nurses
- independent nurse midwives
- independent nurse practitioners
- Indian health centers
- mental health centers
- municipally based health service providers
- ocularists
- opticians
- optometrists
- optometry schools
- orthotics providers
- oxygen and respiratory therapy equipment providers
- personal care agencies
- personal care attendant (PCA) fiscal intermediaries
- physicians
- podiatrists
- prosthetics providers
- psychiatric day treatment providers
- psychologists
- qualified-Medicare-beneficiaries-only providers (QMB-only) submitting crossover claims
- rehabilitation centers
- renal dialysis centers
- speech and hearing centers
- sterilization clinics
- substance abuse treatment programs
- targeted case management programs
- therapists
- transportation providers

Entering Information on the CMS-1500 Claim Form

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY or MMDDYYYY format.

  Example: For a member born on February 28, 1960, the entry would be as follows: 02281960.

Time Limitations on the Submission of Claims

Claims must be received by MassHealth within 90 days from the date of service or the date of the explanation of benefits from another insurer. For additional information about the deadlines for submitting claims, please see MassHealth billing regulations (beginning at 130 CMR 450.309).

Claims for Members with Medicare or Other Health-Insurance Coverage

Special instructions for submitting claims for services furnished to members with Medicare or health-insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, refer to Subchapter 5, Part 3 of your provider manual or contact MassHealth Customer Service. Refer to Appendix A of your provider manual for contact information.

Where to Send Paper Claim Forms

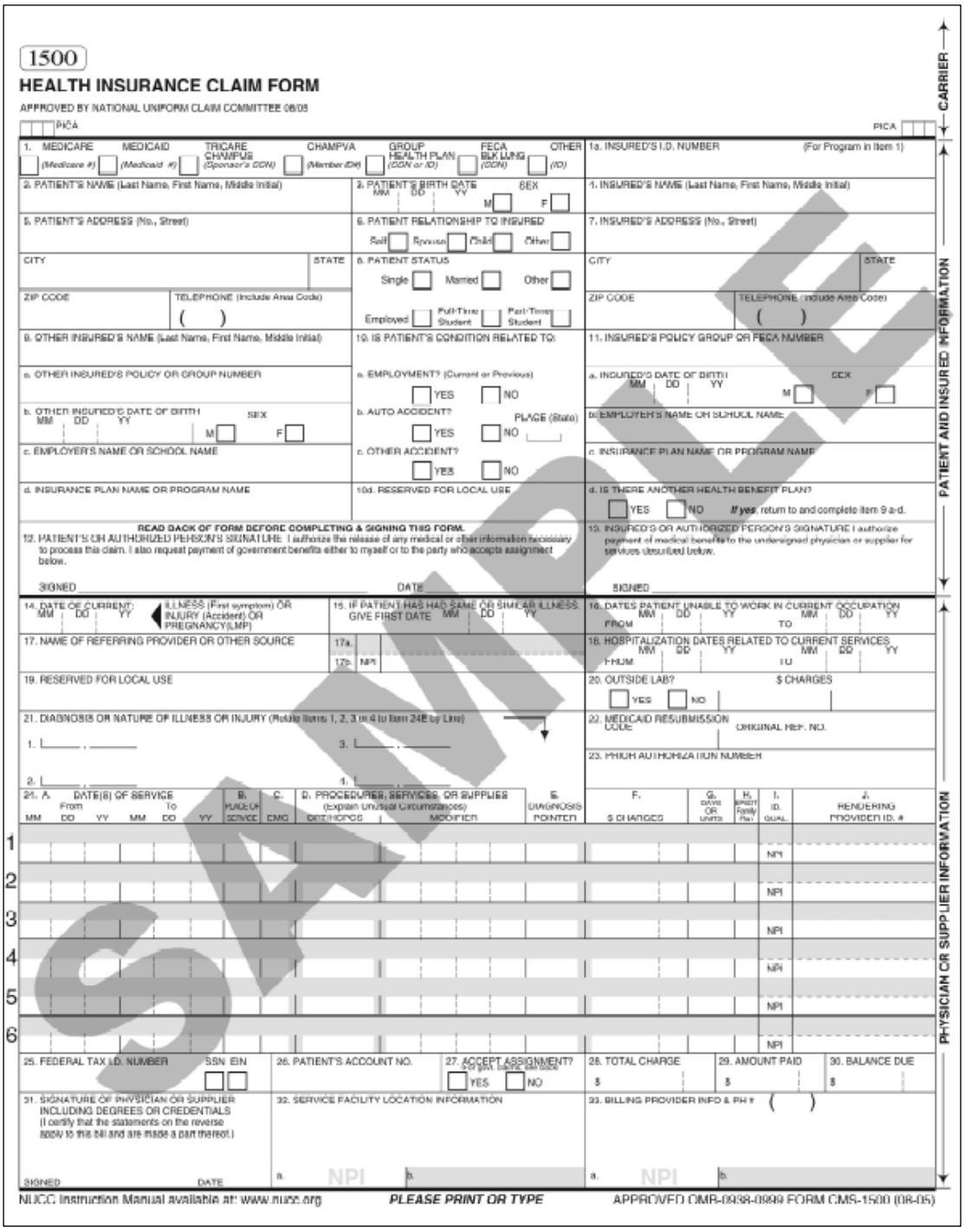
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following instructions for completing the CMS-1500 claim form, you need additional assistance, you can contact MassHealth Customer Service. Please refer to Appendix A for all MassHealth Customer Service contact information.

How to Complete the CMS-1500 Claim Form

A sample CMS-1500 claim form is shown below. Following this sample are instructions for completing each field on the CMS-1500 claim form. Refer to the National Uniform Claim Committee (NUCC) instruction manual available at www.nucc.org. Many types of providers use the CMS-1500 claim form to bill MassHealth for services. In some cases, special instructions have been provided for specific services or situations. Complete each field as instructed generally and follow specific instructions for your provider type or situation, as applicable.



How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
1	(Unnamed)	Indicate the type of health-insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's I.D. Number	Enter the complete 12-character member identification (ID) number that is printed on the MassHealth card. If the Medicare box is checked in Field 1, enter the member's HIC (health insurance claim) number.
2	Patient's name	Enter the name of the MassHealth member receiving services in the following order: last name, first name, middle initial.
3a	Patient's Birth Date (DOB)	Enter the patient's eight-digit birthdate in MM/DD/YYYY format.
	Sex	Enter an X in the correct box to indicate the gender of the patient. Only one box can be marked. If the gender is unknown, leave this field blank.
4	Insured's Name	If the member has other insurance, enter the insured's name in the following order: last name, first name, middle initial.
5	Patient's Address	Not required
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to the insured. Only one box can be marked.
7	Insured's Address	Not required
8	Patient Status	Not required
9	Other Insured's Name	If Field 11d has an entry, complete Fields 9 and 9a-9d, as applicable. When additional group health coverage exists, enter the name of the other insured in the following order: last name, first name, middle initial.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured, if applicable.
9b	Other Insured's Date of Birth, Sex	Enter the eight-digit date of birth of the other insured in MM/DD/YYYY format. Enter an X in the applicable box to indicate the gender of the other insured. Only one box can be marked. If the gender is unknown, leave this field blank.
9c	Employer's Name or School Name	Enter the name of the other insured's employer or school.
9d	Insurance Plan Name or Program Name	Enter the seven-digit MassHealth third-party-liability carrier code. Refer to Appendix C of your MassHealth provider manual for carrier code values.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
10a	Is Patient's Condition Related to: Member's Employment	Enter an X in the appropriate box to indicate whether the condition is employment-related.
10b	Auto Accident Place (State)	Enter an X in the appropriate box to indicate the type of accident. If Yes is marked, also enter the state postal code where the accident occurred.
10c	Other Accident	Enter an X in the appropriate box to indicate if the condition is the result of any other type of accident.
10d	Reserved for Local Use	If submitting a crossover claim, enter the complete 12-character member identification (ID) number that is printed on the MassHealth card.
11	Insured's Policy Group or FECA Number	If applicable, enter the insured's policy or group number as it appears on the insured's health-care identification card. If Field 4 is completed, this field must also be completed.
11a	Insured's Date of Birth, Sex	Enter the insured's eight-digit birthdate in MM/DD/YYYY format. Enter an X in the correct box to indicate the gender of the patient. Only one box can be marked. If the gender is unknown, leave this field blank.
11b	Employer's Name or School Name	Not required
11c	Insurance Plan or Program Name	Enter the seven-digit MassHealth third-party-liability carrier code. Refer to Appendix C of your MassHealth provider manual for carrier code values.
11d	Is There Another Health Benefit Plan	Enter an X in the appropriate box to indicate whether or not there is another health benefit plan. If Yes, complete Fields 9 and 9a through 9d. Make an entry in only one box.
12	Patient's or Authorized Person's Signature	Not required
13	Insured's or Authorized Person's Signature	Not required
14	Date of Current: Illness, Injury, Pregnancy	Enter the start date of the present illness, injury, or condition in MM/DD/YYYY or MM/DD/YY format. For pregnancy, use the date of the last menstrual period (LMP).

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
15	If Patient Has Had Same or Similar Illness	Not required
16	Dates Patient Unable to Work in Current Occupation	Not required
17	Name of Referring Provider or Other Source	Enter the name and credentials of the professional who referred, ordered, or supervised the service(s) or supply(ies) on the claim in the following order: first name, middle initial, last name.
17a	Other ID#	If the referring provider has an NPI, if applicable, enter the provider's taxonomy code with a qualifier of ZZ. If the referring provider is atypical and does not have an NPI, enter the 10-character MassHealth provider ID with a qualifier of 1D.
17b	NPI	Enter the NPI number of the referring provider. If the referring provider does not have an NPI, this field is not required.
18	Hospitalization Dates Related to Current Services	If the member has been hospitalized, enter the inpatient hospital admission start date and discharge date (if the patient has been discharged) in MM/DD/YYYY format. If the patient has not been discharged, leave the discharge date blank. *Psychiatric Day Treatment Providers:* Enter the date of the member's discharge from the program.
19	Reserve for Local Use	Not required unless otherwise noted. *Durable Medical Equipment (Repairs):* If the repair does not require prior authorization, enter the following information: • the name of the person who requested the repair; • the date of the request and a specific description of the equipment malfunction; • a list of procedures and parts used to complete the repair; • the cost of each procedure and part; and • the time required to complete the repair. If there is not enough space in this field, submit an attachment with the claim containing the above-mentioned information.
20	Outside Lab? $ Charges	Not required

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
21	Diagnosis or Nature of Illness or Injury (relate items 1, 2, 3, or 4 to 24E by line)	Enter the ICD-9-CM diagnosis code. If there is a fourth or fifth digit, it is a required part of the code. Enter up to four ICD-9-CM codes. Relate lines 1, 2, 3, and 4 to the lines of service in Field 24E by line number. Use the highest level of specificity. Do not provide a narrative description in this field. When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than three beginning digits (for example, E codes), enter the fourth digit over the period.
22	Medicaid Resubmission Code, Original Ref. No.	*For Adjustments:* When requesting an adjustment to a paid claim, enter an "A" followed by the 13-character internal control number (ICN) assigned to the paid claim. This ICN appears on the remittance advice on which the original claim was paid. (When submitting an adjustment, include all the lines that were on the original claim. Correct the line that needs to be adjusted.) *For Resubmittals:* When resubmitting a denied claim, enter an "R" followed by the 13-character ICN assigned to the denied claim. This ICN appears on the remittance advice on which the original claim was denied. (When submitting a resubmittal, include all the lines that were on the original claim. Correct the line that was denied.)
23	Prior Authorization Number	Enter the prior-authorization number or referral number assigned by MassHealth, if applicable.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24	(Unnamed Shaded Area)	Enter the following information in the shaded area of Lines 1-6 from the beginning of 24A to the end of 24G for up to 61 characters. *For Drugs or Injectable Devices Administered in the Office*: If billing for drugs or injectable devices administered in the office, except vaccines, enter the following information: • Qualifier N4; • the national drug code (NDC); • the NDC unit of measure; and • the quantity of the drug administered. This information is in addition to the Healthcare Common Procedure Coding System (HCPCS) code entered in the unshaded section on the same line. Use the following qualifiers when reporting NDC units: • F2: international unit (for example, anti-hemophilia factor); • GR: gram (for creams, ointments, and bulk powders); • ML: milliliter (for liquids, suspensions, solutions, and lotions); and • UN: unit (for tablets, capsules, suppositories, and powder-filled vials). *For Medical Supplies:* If billing for medical supplies that are listed in Subchapter 6 of your MassHealth provider manual as requiring individual consideration (IC), enter a complete description of the item and the acquisition cost in addition to the quantity dispensed, and attach a copy of the supplier's invoice. Invoices submitted with a claim must be dated no more than 18 months before the date of service. One invoice indicating all the items for which payment is requested is acceptable.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24A	Date(s) of Service	Enter the date the service was provided in MMDDYYYY format. *For a Single Date of Service:* In the "From" column, enter the date the service was provided in MMDDYYYY format. Leave the "To" column blank. *For Consecutive Dates of Service:* In the "From" column, enter the first date of service. In the "To" column, enter the last date of service. Billing for consecutive dates of service on a single claim line is allowed for only certain services. For example, a physician may bill for hospital visits on successive days by entering the dates of service in the "From" and "To" boxes, but a physician may not bill for office visits on successive days on a single claim line. *Early Intervention Providers:* *For Assessments:* Enter the date the assessment was completed in the "From" column. In Field 24G, enter the total number of units spent on the assessment, regardless of the date. *For All Other Early Intervention Services:* Follow the instructions given in the general description. *DME and Oxygen and Respiratory Therapy Equipment Providers:* *For monthly rentals:* Enter the last date of the monthly rental period in "From." Leave "To" blank. Use a separate claim line for each monthly rental period. *For substitute rentals:* Enter the date of service in "From"; leave "To" blank. Use a separate claim line for each rental day. *For purchases and repairs:* Enter the date when the service was furnished in "From." Leave "To" blank.
24B	Place of Service	Enter the appropriate two-digit code from the place-of-service code list for each item used or service performed. The place-of-service codes are available at: www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDataBase.pdf.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24C	EMG	Indicate if the service is the result of an emergency. Valid values are: Y, N, or blank.
24D	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s). This field accommodates up to four two-digit modifiers. See Subchapter 6 of the applicable MassHealth provider manual for lists of payable or nonpayable service codes and modifiers and their descriptions. *Municipally Based Health Service Providers:* Municipally based health service providers should refer to relevant municipally based health service provider bulletins to determine the correct service code. *Transportation Providers:* Use modifier "TS" when billing for more than two one-way trips for the same member on the same date of service.
24E	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. (ICD-9-CM diagnosis codes must be entered in Field 21 only. Do not enter them in Field 24E.) When multiple services are performed, enter the primary reference number for each service first followed by other applicable services. The reference number should be a 1, 2, 3, 4, or multiple numbers as explained. Enter numbers left-justified in the field. Do not use commas between the numbers.
24F	$ Charges	Enter the provider's usual and customary fee (amount charged to a person who is not a MassHealth member). Enter the amount right-justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number. *For Medical Supplies, Medications, and Injectables:* Enter the actual acquisition cost and attach a copy of the supplier's invoice to the claim. Invoices submitted with a claim must be no more than 18 months before the date of service. *Durable Medical Equipment and Oxygen and Respiratory Therapy Equipment Providers:* If billing for a monthly rental in which the actual number of days is less than one month, divide the monthly usual and customary fee by the number of days in the month, multiply this by the number of rental days, and enter this amount.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24F	$ Charges (cont.)	*Personal Care Agencies:* *For Functional Skills Training:* Enter the standard charge per member per month, regardless of the number of skills training sessions provided to the member in the month. *For Initial Evaluations and Reevaluations:* Enter the provider's usual and customary fee.
24G	Days or Units	Enter the appropriate number of units billed on the claim line for the service date. *For Consecutive Days of Service*: Enter the total number of days or units within the billing period. *For Nonconsecutive Dates of Service:* Enter "1" for each date of service or unit entered on the claim form. *For Anesthesia:* Enter the total number of 15-minute periods, including as one unit any remaining fraction that equals or exceeds five minutes, that make up the beginning and ending clock time for the anesthesia service. See 130 CMR 433.000 for regulations about reporting anesthesia time. If no units are entered, the service is paid at the base rate.

Field No.	Field Name	Description
24H	EPSDT/Family Plan	*Early and Periodic Screening, Diagnosis, and Treatment:* Enter the response in the shaded portion of the field as follows. If there is no requirement (for example, state requirement) to report a reason code for EPDST, enter "Y" for yes, or "N" for no. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. • AV: Available–Not Used (Patient refused referral.) • S2: Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) • ST: New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) • NU: Not Used (Used when no EPSDT patient referral was given.) *Family Planning:* If the service is for family planning, enter "Y" for yes, or "N" for no in the bottom unshaded area of the field.
24I	ID Qual.	Enter in the shaded area of Field 24I the qualifier identifying if the number is a non-national provider identifier (NPI). Enter 1D if the provider is an atypical provider and does not have an NPI. Enter "ZZ", if the provider has an NPI and is providing taxonomy information.
24J	Rendering Provider ID #	If the shaded area of Field 24I is "1D," enter your MassHealth provider ID in the shaded area of Field 24J. If the shaded area of Field 24I is "ZZ," enter the provider taxonomy code if applicable in the shaded area of Field 24J. Enter the provider's NPI in the unshaded area of Field 24J.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
25	Federal Tax ID Number	Enter the service or supplier federal tax ID (employer identification number) or social security number for the provider. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Patient's Account No.	Enter the patient's account number, if one is assigned by the servicing provider or supplier's accounting system.
27	Accept Assignment? Yes or No	*For Non-Crossover Claims:* Leave this field blank. *For Crossover Claims:* Enter an X in the appropriate box to indicate whether the provider accepts assignment.
28	Total Charge	Enter the total charges for the services (that is, the total of all charges in Field 24F). Enter the amount in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number.
29	Amount Paid	Enter the total amount the patient or other payers paid on the covered services only. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number.
30	Balance Due	Enter the total amount due. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number.
31	Signature of Physician or Supplier Including Degrees or Credentials, Date	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the six-digit date (MM/DD/YY), eight-digit date (MM/DD/YYYY), or alphanumeric date (for example, January 10, 2008) that the form was signed.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
32	Service Facility Location Information	Enter the name, address, city, state, and zip code of the location where the services were provided. Providers of the service (namely physicians) must identify the supplier's name, address, zip code, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, use a separate CMS-1500 claim form for each supplier. Enter the name and address information in the following format: • 1st line: name • 2nd line: address • 3rd line: city, state, and zip code Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a nine-digit zip code, include a hyphen.
32a	NPI	Enter the NPI of the service facility location in Field 32.
32b	Other ID No.	Enter the two-digit qualifier identifying the non-NPI number, followed by the ID number. If the provider is an atypical provider and does not have an NPI, enter "1D," followed by the provider's 10-character MassHealth provider ID. Enter "ZZ" if the provider has an NPI and is providing taxonomy information followed by the taxonomy code.
33	Billing Provider Info & Phone #	Enter the provider's or supplier's billing name, address, zip code, and phone number. Enter the phone number in the area to the right of the field title. Enter the name and address information in the following format: • 1st line – name • 2nd line – address • 3rd line – city, state, and zip code Field 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a nine-digit zip code, include a hyphen. Do not use a hyphen or space as a separator within the telephone number.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
33a	NPI	Enter the NPI of the billing provider.
33b	Other ID No.	Enter the two-digit qualifier identifying the non-NPI number, followed by the ID number. If the provider is an atypical provider and does not have an NPI, enter "1D" followed by the provider's 10-character MassHealth provider ID. Enter "ZZ" if the provider has an NPI and is providing taxonomy information followed by the taxonomy code.